

Pre Fix	Prior Error	NUMBER HOLDER IDENTIFICATION			SOCIAL SECURITY NUMBER			
		LAST NAME	FIRST NAME	MI				
SS	PR 9				AN			
		GRANT REIMBURSEMENT						
		GR	1 7 8 8 0					

I, the undersigned, authorize the Secretary of the United States Department of Health and Human Services (U.S. DHHS) to send my initial posteligibility payment of supplemental security income (SSI) benefits to the State of Kansas, Department of Social and Rehabilitation Services.

I further authorize the Department of Social and Rehabilitation Services to deduct from my initial posteligibility payment an amount equal to the sum of all public assistance benefits (not including assistance payments financed wholly or partly with Federal funds) made to, or on behalf of, me by the Department of Social and Rehabilitation Services beginning with the day of the month my SSI benefits are reinstated after a period of suspension or termination, and ending with (and including) the month my SSI benefits resume.

I understand that after making the above deductions from my first payment, the Department of Social and Rehabilitation Services shall pay to me the balance, if any, no later than 10 working days from the date the Department of Social and Rehabilitation Services receives my initial posteligibility payment from the Secretary of the U.S. DHHS.

I further understand that I have the right to a fair hearing before the Department of Social and Rehabilitation Services if I feel that the amount deducted from my initial posteligibility payment of SSI benefits was more than the amount of public assistance benefits paid to, or on behalf of, me by the Department of Social and Rehabilitation Services.

I further understand that this authorization is effective from the date I sign it and that it will cease to have affect either at the end of one (1) year from the date signed, or at the end of the maximum period permitted under regulations at Subpart N of 20 CFR within which to request administrative or judicial review of the determination by the Secretary of the U.S. DHHS to suspend or terminate my SSI benefits, whichever period of time is longer, unless I file a request within the time for such review, or one of the following events occurs earlier, in which case the authorization will cease to have effect as of the date of such an event: (1) The Secretary of the U.S. DHHS releases the retroactive payment on my claim or record which has been reinstated to payment after a period of suspension or termination; or (2) the Secretary of the U.S. DHHS makes a final determination on my claim and no timely request for review is filed by me; or (3) the State and I agree to terminate the authorization.

Signature

Date

Address

Phone #

FOR SRS USE ONLY

Case Number \_\_\_\_\_

Signature of IM Worker Date

SRS Office and Address

FOR SSA USE ONLY

First month of suspense or non-payment:

Redetermination or appeal initiated:

☐ Yes, date:

☐ No (indicate reason below):

- ☐ Case already in current pay status.
- ☐ Case terminated, new claim needed.
- ☐ Client failed to pursue.
- ☐ Unable to locate client.
- ☐ Other: \_\_\_\_\_

Signature of SSA Representative

Date

SSA Office and Address

Distribution: Original and Copy, SSA; Copy, Applicant; Copy, IM Case File; Copy, Central Office